

Accreditation — the trainee's dilemma

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INTRODUCTION

A postal survey of all Senior Registrars (SRs) in training was conducted to ascertain the views of the SRs on the subject of accreditation. In particular it had been anticipated that there will be a large shortfall of accredited SRs in accident and emergency (A&E) to fill the current and expanding numbers of consultant posts. The survey sought to clarify the position and to audit the retrospective recognition awarded to current SRs in training.

METHODS

A postal questionnaire (Fig. 1) achieved a response of 62 returns from the 65 SRs questioned (95%). The survey was conducted between December 1991 and January 1992.

RESULTS

The current position of SRs in A&E as regards accreditation dates is shown in Fig. 2. The large number (14) currently awaiting accreditation dates reflects the spate of recent SR appointments and most of these will not be accredited until late 1994 or early 1995. Of those SRs accredited in 1991 and 1992, 18 of the 27 had already been appointed to consultant posts but had not yet taken up the post. This leaves a 'pool' of nine SRs who are (four) or will be (five) accredited by the end of 1992.

Retrospective recognition of training as granted by the Higher Training Committees showed a variation between 0 and 24 months with a mean of 13 months (Fig.2).

Fig. 1. Senior registrars accreditation survey — postal questionnaire.

BRITISH ACCIDENT & EMERGENCY TRAINEES ASSOCIATION
BAETA
SENIOR REGISTRARS ACCREDITATION SURVEY

Name: _____

Current Post Held: _____

(Please indicate if you have recently been appointed to a consultant post but have not yet taken up the post)

Date appointed: _____ Accreditation date: _____

Amount of Retrospective Recognition granted: _____

(Please indicate if you have not yet applied to the Joint Committee on Higher Medical Training for enrolment for Higher Medical Training)

Would you consider applying for a suitable consultant post prior to achieving full accreditation?: _____

Any general comments you have with regards to the question of accreditation would be welcome (eg. essential, irrelevant, preferable etc.): _____

Thank you for your time

In response to the question, 'would you consider applying for a suitable consultant post prior to achieving full accreditation?', 28 SRs said they would and 28 said that they would not apply. Two had been appointed to consultant posts and gave no answer, whilst four said they would apply if within 6 months of

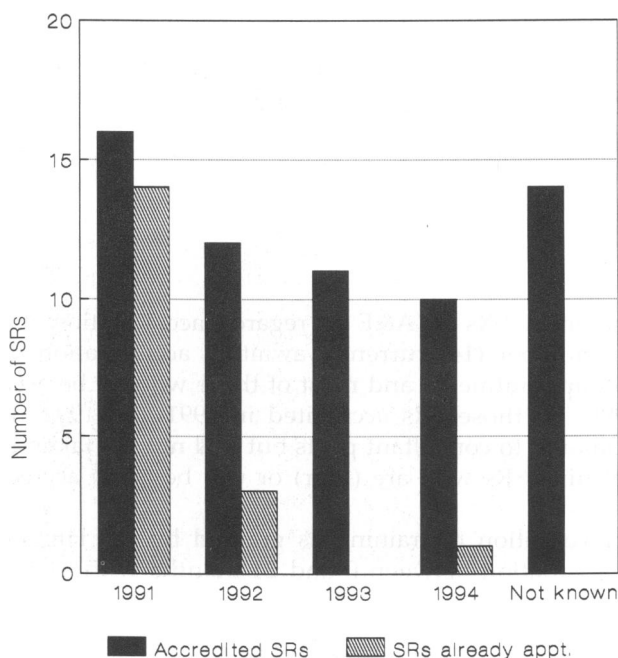


Fig. 2. Current SR accreditation dates (SR sample — January 1992).

accreditation or if the job was particularly attractive. Respondents were asked to give general comments about the issue of accreditation. Although a majority of SRs said that they would apply for suitable consultant posts irrespective of accreditation status, many commented that as a general principle accreditation is preferable for the specialty. The introduction by the GMC of 'specialist' registration and the introduction of fixed term contracts by trust status hospitals, with perhaps the move towards greater movement of appointed consultants around the country in the future, make accreditation more desirable.

A minority expressed the view that accreditation is irrelevant, as consultant posts could be obtained without it and that some appointment committees had appointed non-accredited candidates in preference to those accredited. There was concern about the appointment to some posts of candidates from other disciplines who had had no formal higher A&E training.

Comments regarding retrospective recognition suggested that insufficient information was given to applicants on the amount of recognition awarded (Fig. 3). A suggestion was made that the numbers in the SR grades were small enough to make it a feasible proposition that individual interviews were held between the SR and the Higher Training Committee. This would give the opportunity to discuss each SRs further training requirement needs.

It was felt that there were inconsistencies in the recognition of SHO posts held either before or after a period as an A&E registrar. Many felt that these often provided better experience and more responsibility than secondments held at SR level.

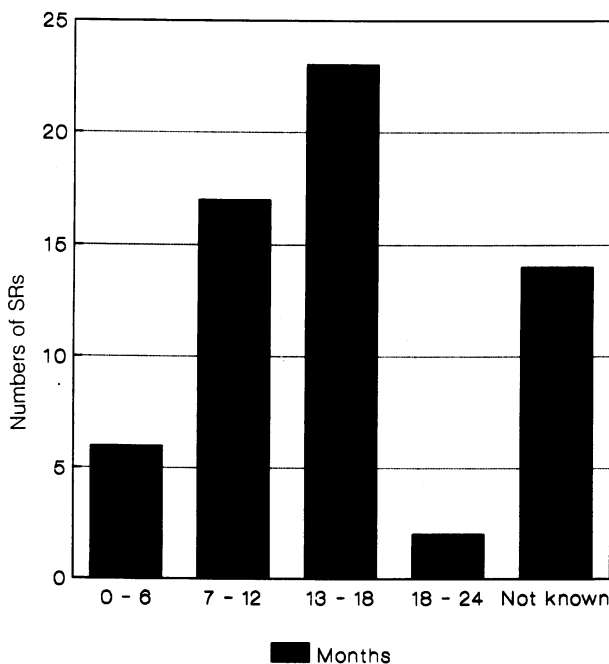


Fig. 3. Retrospective Recognition for training (SR sample – January 1992).

DISCUSSION

Theoretically, 65 SRs each spending on average 3.1 years in post (BAEM, 1992), should lead to approximately 21 accredited SRs becoming available to take up consultant posts each year.

Estimates of the predicted number of consultant post vacancies from retirements and newly formed posts by expansion vary widely. *The Way Ahead* (BAEM, 1992) quotes 20 retirements and currently six or seven new posts per year with a recommendation that 20 new posts per year be created each year for the next 10 years. *Health Trends* quotes six per year with an anticipated growth of 12 new posts a year. The Specialist Advisory Committee (SAC) quote figures from September 1990 to September 1991 of 14 replacement vacancies and 32 new posts offered of which 21 remained unfilled at the end of that year.

Joint Planning Advisory Committee (JPAC) have recently announced approved increases in the number of career SR posts from the current level of 65 to 105 and career Registrar posts to 100. These posts will need to be funded by the Regions and it is unrealistic to expect such a rapid expansion allowing for past experience of expansion with smaller numbers of SRs (BAEM, 1992).

However, 60 A&E departments in England & Wales still have no A&E consultant in charge and the Royal College of Surgeons of England has indicated that it will not approve departments for training SHOs unless they have an A&E consultant in charge. The BAEM (1992) has also advocated that A&E departments that do not have full time A&E consultant supervision should be closed to ambulances and should not be permitted to provide general professional training to SHOs.

This has put pressure on Health Authorities to appoint A&E consultants in hospitals where no consultant is currently in post. This partly accounts for the large expansion in the number of new A&E consultant posts, added to this is the fact that many consultants appointed in the late 1970s, relatively late in their professional lives, are now approaching retirement.

SRs currently in training who feel that they are capable of taking up a consultant post although they may not be fully accredited, therefore face a dilemma. On the one hand there are an abundant number of consultant posts available around the country that they could fill adequately, but at what risk in terms of being non-accredited?

Advice from the SAC suggests that retrospective accreditation is very unlikely to be awarded unless the candidate is or was within 3–6 months of his/her accreditation date at the time of taking up a consultant appointment. The President of the British Association for Accident & Emergency Medicine, in reply to a report that after appointment to a consultant post, 6 months ahead of his accreditation date, a member had been refused accreditation by the SAC, said that '... the object of accreditation was to achieve consultant status and once that status had been reached, accreditation was of less relevance (BAEM, 1991). There are widely differing views and practices with regard to accreditation amongst the different specialties (Lister, 1985), with varying views from each college. It is currently recognized that at present no candidate for a consultant post should be excluded from a short list solely on account of his lack of accreditation and it should be recognized that the

ultimate accreditation committee is in fact the Advisory Appointment Committee (AAC).

The college representatives on the AAC can exert maximum influence on the selection of consultants through their nominated assessors, who should be able to help the committees to select the most suitable candidate for the post (Lister, 1985).

In conclusion, therefore, there is already a large gap between the pool of available accredited SRs in A&E and the number of expanding consultant posts. Perhaps this is the time as in other specialties for a review of the current accreditation system and an appraisal of its worthiness as it currently stands. This is happening in other specialties (Brearly, 1992). The problem within the specialty of A&E medicine is more acute because of its need for growth. Coupled with that growth must be a maintenance of standards of training that will command the respect of other specialties.

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